

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8129341						
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR						
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Charles Phillips Adams, Sr.						September 6, 1903			78 YRS							
3. SEX Male			4. RACE Caucasian			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles			MD.	
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Retired							
13a. STATE Maryland			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Takoma Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7214 Trescott Avenue				
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Adams Anna			16. SOCIAL SECURITY NO. No. 578-07-5783			17. INFORMANT John W. Adams			18. ADDRESS 4901 Riverton Lane, Bowie, Maryland 20715			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured aortic aneurysm</i>																
4415 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____										DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION 11-21-81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ruptured aortic aneurysm</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21-81</u> , 19 <u>81</u> , to <u>11-22-81</u> , 19 <u>81</u> , that (I) (we) lost sow the deceased alive on <u>11-21-81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11-22-81						
22b. SIGNATURE <i>Chinmoy Banerjee</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chinmoy Banerjee, M.D.			22e. ADDRESS Waldorf, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/25/1981			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION CITY OR TOWN Colmar Manor			COUNTY P.G. Md.		STATE		
24. FUNERAL DIRECTOR NAME John Phillips			ADDRESS 11010 Fairmount Avenue, Suite 257, Laurel, MD 20708			25. DATE REC'D. BY REGISTRAR 11-22-81			26. DATE OF TRANSMISSION 11-22-81							



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 9 3 4 2	
1 - FOR STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)				MIDDLE			LAST				2a. DATE OF DEATH		
MELISSA N							AKERS				11/1/1981		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR				
FEMALE		WHITE		MONTH 08 / DAY 07 / YEAR 73			8 8		2:25 A				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Charles County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
La Plata		Physician's Memorial Hospital		Student			N/A						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Char		Newburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 26				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST						
Howard D. Akers				Alice Akers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
No		N/A		217-84-8532			Alice Akers		Same As 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest.												3-2 hrs.	
3439 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
DUE TO, OR AS A CONSEQUENCE OF (b) Severe hypoxia.													
DUE TO, OR AS A CONSEQUENCE OF (c) ? cerebral polyp.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
None.		—		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 10/31 1981 to 10/31 1981, that (I) (we) last saw the deceased alive on 11/01 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE		22d. DATE SIGNED									
Terry A. Boutwell M.D.				10/01/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Terry A. Boutwell M.D.		701 E. Charles St., La Plata, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE						
Cremation		Nov. 3, 1981		Lee's Crematory			Washington, D.C.						
24 FUNERAL DIRECTOR		Lee Funeral Home, Inc.		25e. DATE REC'D. BY REGISTRAR			25d. REGISTRAR'S SIGNATURE						
6633 Old Alexander Ferry Road, Clinton, MD				NOV 4 1981			James Jean Kithen						
DHMH-16 30M 2/80 (VRA 15, 4)													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29345				
1- FOR STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 11 15 19 81									2b. HOUR 24 HOUR 10:45 a.m.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST Robert			MIDDLE Walter			LAST Almond			7b. DATE OF ESTI- DEATH MATED <input type="checkbox"/>				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR April 28 46			6. AGE (IN YEARS LAST BIRTHDAY) 35 yrs.			7c. DATE PRONOUNCED DEAD 11 15 19 81				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.							
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heavy Equip. Oper. of Md.				
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN Indian Head			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. #1 Box 52				
14. FATHER'S NAME FIRST Earl			MIDDLE Edward			LAST Almond, Sr.			15. MOTHER'S MAIDEN NAME FIRST Mildred			MIDDLE Elizabeth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1965-1969			17. INFORMANT 215-46-3676			18. INFORMANT Mother- Mildred Almond			ADDRESS Same as Line #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head (Handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY ? P.M. 11 15 19 81			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted			21d. LOCATION STREET Glymont			CITY OR TOWN Indian Head, Charles, MD.				
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) yard			22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) ACTUAL SIGNATURE <i>Thomas D. Smith, M.D.</i> Deputy Chief MEDICAL EXAMINER			DATE SIGNED 11/16/81							
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-20-81			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans			23d. LOCATION CITY OR TOWN Cheltenham P.G.			COUNTY STATE Maryland				
24 FUNERAL DIRECTOR NAME Hunt Funeral Home			ADDRESS Waldorf, Maryland									25a. DATE REC'D. BY REGISTRAR NOV 23 1981			25b. REGISTRAR'S SIGNATURE <i>James Jan Walker</i>	
DHMH-17 (VR A15 ME (5)) 15M 2/80																

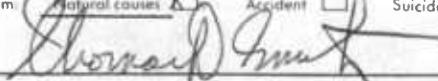


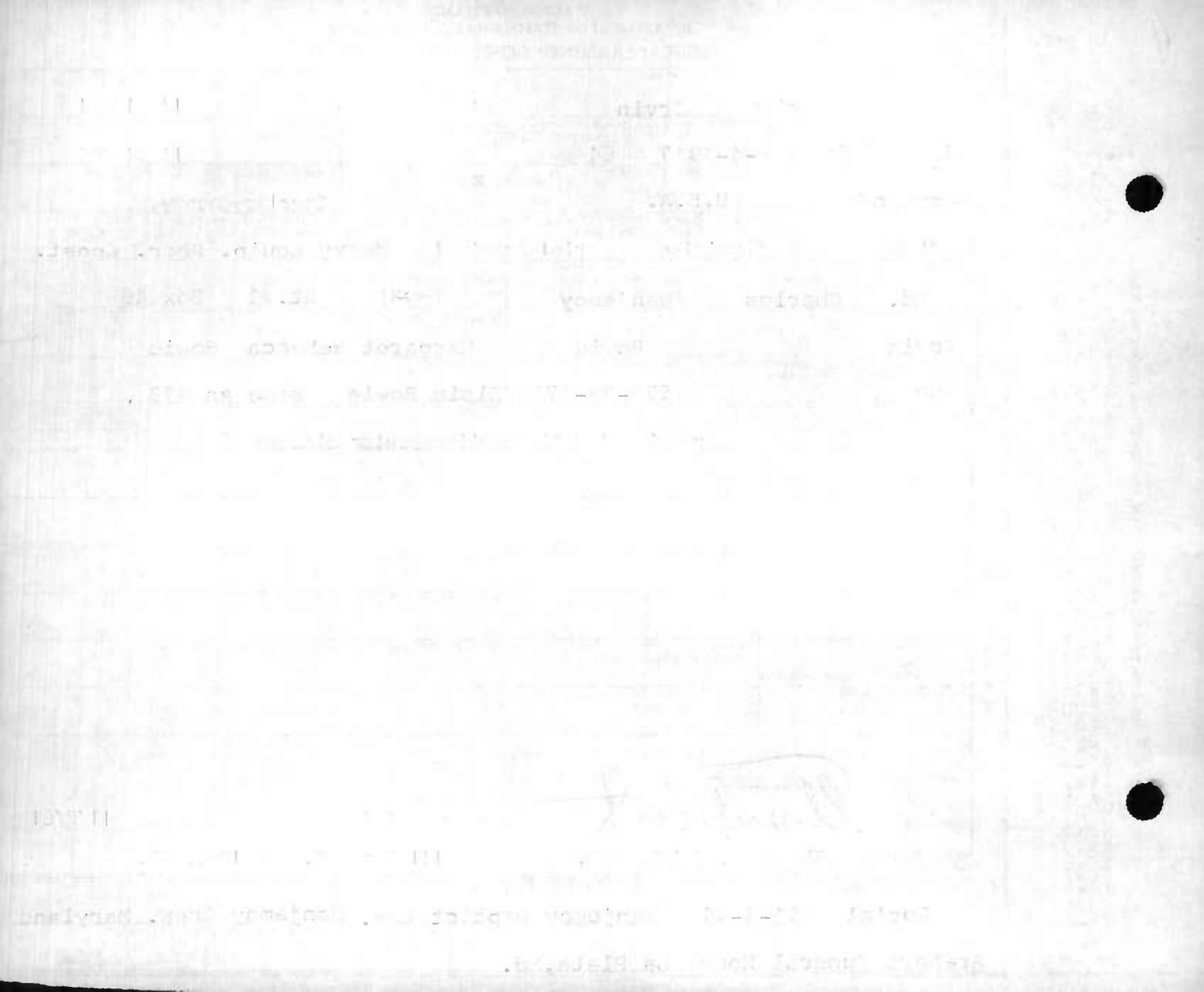
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29344  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR		
Charles Irvin Bowie						<input checked="" type="checkbox"/>	11	1	1981	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE Pronounced Dead	MONTH	DAY	YEAR	2d HOUR		
Male	White	6-4-1917	64 yrs.			<input checked="" type="checkbox"/>	11	1	1981	3:29P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.					Charles County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
La Plata		Physicians Memorial Hospital			Heavy Equip. Poc. Const.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Md.		Charles		Nanjemoy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #1 Box 45				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Irvin				Bowie		Margaret Rebecca Bowie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			579-09-9716			Elsie Bowie			same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) P.M. 19						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Actual Signature 											TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)											DATE SIGNED 11/2/81	
Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Baltimore, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		11-4-81		Nanjemoy Baptist Cem.			Nanjemoy		Chas.		Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Arehart Funeral Home		La Plata, Md.		NOV 12 1981			Thomas Jean Nathan					

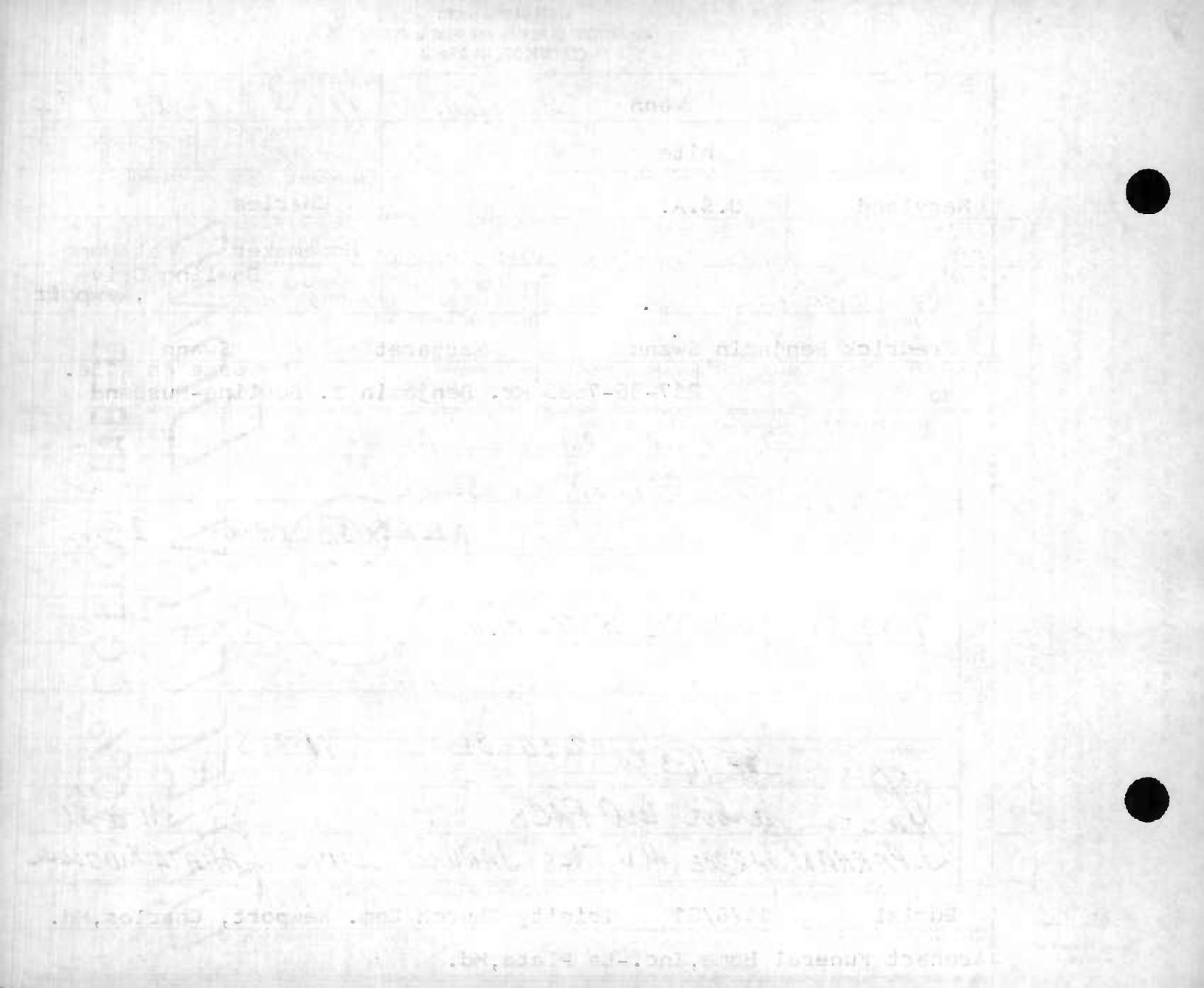


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	9	3	4	5									
												REG. NO.															
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
			LESSIE			Swann						BOWLING			11			- 3		- 81		927		AM			
3 SEX			4. RACE			5. DATE OF BIRTH			MONTH			DAY			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 MRS.							
FEMALE			White			9 - 28 - 03									78			YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Charles									
Maryland			U.S.A.						WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																		
LA PLATA			PHYSICIANS MEMORIAL HOSPITAL			Homemaker																					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			Bowling Drive RT 1 Box 202, Newport												
MARYLAND			CHARLES			CHARLOTTE HALL			YES <input type="checkbox"/> NO <input type="checkbox"/>																		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																								
FIRST Fredrick Benjamin Swann			FIRST Margaret			MIDDLE			LAST Swann																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS			Same as #13e.												
No			217-36-7888			Mr. Benjamin T. Bowling-Husband																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio - Pulmonary Arrest</i>												30 min															
5789 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												1 hr															
(b) <i>Hypovolemic Shock</i>																											
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Massive GI Bleeding</i>												2 hrs															
DUE TO, OR AS A CONSEQUENCE OF																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																		
7-27-81			GASTRIC OBSTRUCTION			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)																					
			P.M. 19																								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE												
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																											
22a. I certify that (1) (this hospital) attended the deceased from <i>7-20-81</i> , 19 <i>10-3-81</i> , 19, to <i>10-3-81</i> , 19, that (1) (we) last saw the deceased alive on <i>10-3-81</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. (1) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <i>J. Parran Jarboe M.D., FACS</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11-3-81</i>																		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Parran Jarboe, M.D., FACS</i>			22e. ADDRESS <i>JARWOOD CLINIC LA PLATA MD 20646</i>																								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/6/81			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Church Cem.			23d. LOCATION CITY OR TOWN Newport, Charles, Md.			COUNTY			STATE												
24. FUNERAL DIRECTOR <i>Arehart Funeral Home, Inc. - La Plata, Md.</i>									25a. DATE REC'D. BY REGISTRAR <i>NOV 12 1981</i>			25b. REGISTRAR'S SIGNATURE <i>Janice J. Weller</i>															



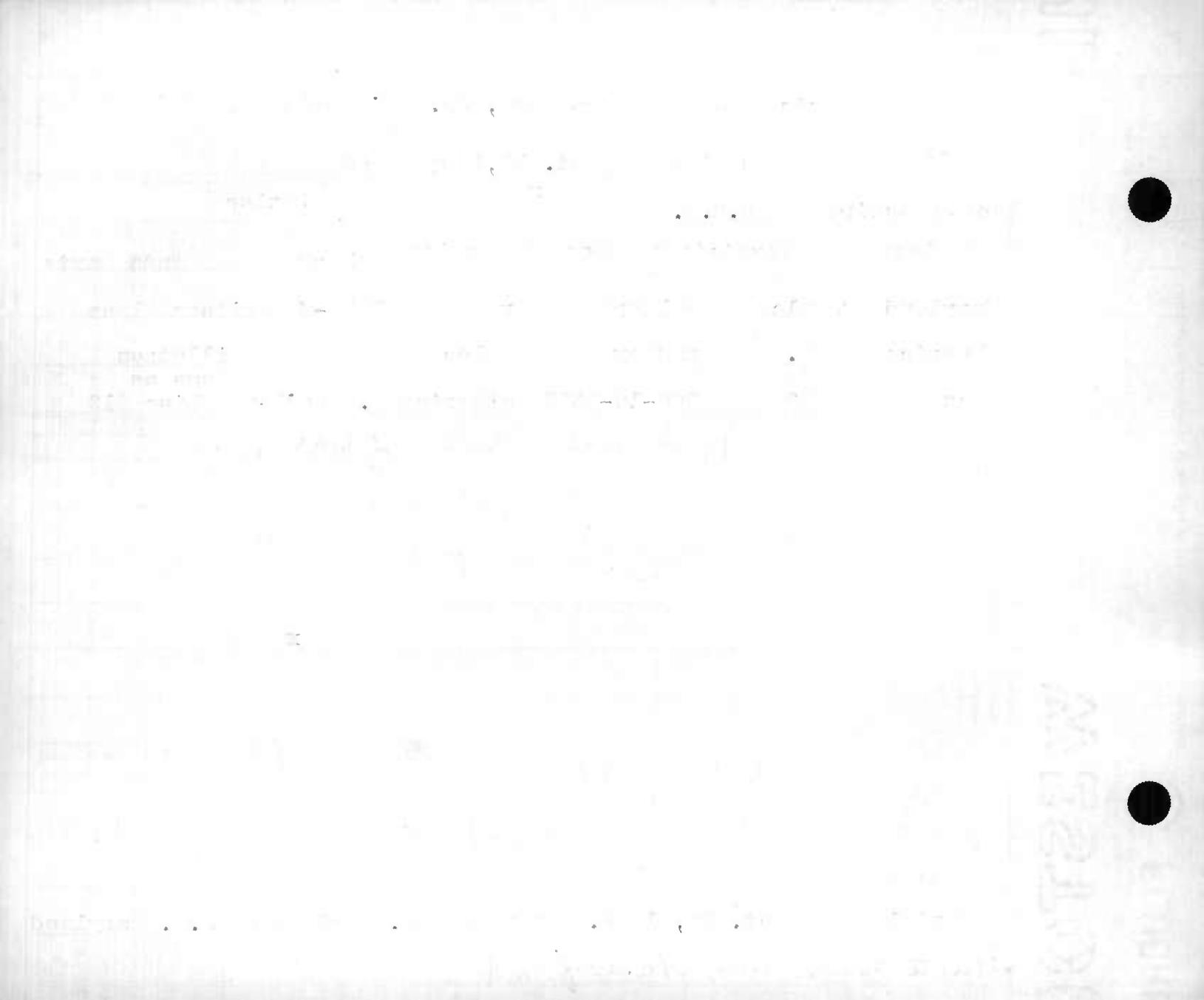
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 9 3 4 6

1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Maurice (nmn)					Bradley, Jr.	November 9, 1981				1:15P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		Caucasian		Oct. 11, 1922		59		YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
New Hampshire		U.S.A.				Charles		LaPlata			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Physicians Memorial Hospital		Clerk				Auto Parts					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Charles		Waldorf		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1112-C Heritage Place			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Maurice		H.		Bradley	Glee				Tillotson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. SAME AS			
Yes		WW2		008-10-5570		Katherine D. Bradley		Line #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:						20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <i>Arterio Cardiac Failure 2nd to Massive Myocardial Infarction.</i>											
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.						DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction.</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Long Standing Schenck and Disease</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8, 1974, to 11/9, 1981, that (I) (we) last saw the deceased alive on 11/9, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (Did) (Did not) view the body after death.											
22b. SIGNATURE <i>George H. Washington</i>		22c. DEGREE				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11/9/81			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) George H. Washington		22g. ADDRESS Waldorf Md. 20601.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		24. LOCATION CITY OR TOWN		25a. COUNTY		25b. STATE	
Burial		Oct. 12, 81		Md. Veterans Cem.		Cheltenham		P.G.		Maryland	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Doris J. Nathan					
DHMH-16 20M (VRA 15, 4) 7/78				NOV 13 1981							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbapapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8129347				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			7a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JOHNSON			Milton						BROWN			NOVEMBER	26	1981		2:20 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS			
MALE		WHITE		MONTH Nov. DAY 11, YEAR 1909			72			MONTHS			DAYS			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY						
North Carolina		U.S.A.		LA PLATA PHYSICIANS MEMORIAL HOSPITAL			Mechanic			Automobile						
14. CITY OR TOWN OF DEATH		15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. INSIDE CITY LIMITS?			17. STREET ADDRESS									
St. Mary		Maryland		Mechanicsville			Rt. #2 Box 339									
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. ADDRESS												
Unavailable		Unavailable		Same as line #13												
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		22. SOCIAL SECURITY NO.		23. INFORMANT		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
NO		N/A		Sharon D. Pusey												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART 1. DEATH WAS CAUSED BY																
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>																
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
4920 (b) <u>Emphysema</u>																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
25. MEDICAL CERTIFICATION		26a. DATE OF OPERATION		26b. CONDITION FOR WHICH OPERATION WAS PERFORMED			26c. AUTOPSY?			26d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
		HOUR A.M. MONTH DAY YEAR														
28. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		29a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		29b. LOCATION			CITY OR TOWN			COUNTY STATE						
28b. I certify that (I) (we) attended the deceased from 11-4-1981 to 11-26-1981, that (I) (we) last saw the deceased alive on 11-26-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
27b. SIGNATURE		27c. DEGREE		27d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			27e. DATE SIGNED									
27e. PHYSICIAN'S NAME (TYPE OR PRINT)		27f. ADDRESS														
GIRIJA S RATH, M.D.		WALDORF, MARYLAND 20601														
28a. BURIAL, CREMATION, REMOVAL (SPECIFY)		28b. DATE		28c. NAME OF CEMETERY OR CREMATORIAL			28d. LOCATION			CITY OR TOWN						
Burial		11-30-81		St. Paul's Church			Waldorf			Charles Md.						
29. FUNERAL DIRECTOR		NAME		ADDRESS			29a. DATE REC'D. BY REGISTRAR			29b. REGISTRAR'S SIGNATURE						
		Huntt Funeral Home		Waldorf, Maryland			DEC 2 1981			John J. Martin						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												29348				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 11 11 1981				2b. HOUR MONTH DAY YEAR				
Charles William Butler																
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 10-10-1919		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		9c. DATE PRONOUNCED DEAD 11 11 1981 7:00A		2d. HOUR MONTH DAY YEAR		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County		MD.								
10. CITY OR TOWN OF DEATH Waldorf				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route #2 Box 206				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2-Box 206 Berry Road								
14. FATHER'S NAME FIRST MIDDLE LAST James Butler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Brawner												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218-07-1919				17. INFORMANT Emma L. Ford				ADDRESS Rt. 1-Box 148 B Waldorf				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemoptes is from carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF 1629 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(b) DUE TO, OR AS A CONSEQUENCE OF																
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Hormez R. Guard, M.D.</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 11/12/81				
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201												
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE Nov. 16/81			23c. NAME OF CEMETERY OR CREMATORIAL St. Peters Ch. Cem			23d. LOCATION CITY OR TOWN Waldorf Chas. Md.		COUNTY	STATE				
24. FUNERAL DIRECTOR NAME Martell Adams Aquasco, Md. 20608			25a. DATE REC'D. BY REGISTRAR NOV 19 1981			25b. REGISTRAR'S SIGNATURE <i>Frances Janithen</i>										
ADDRESS																

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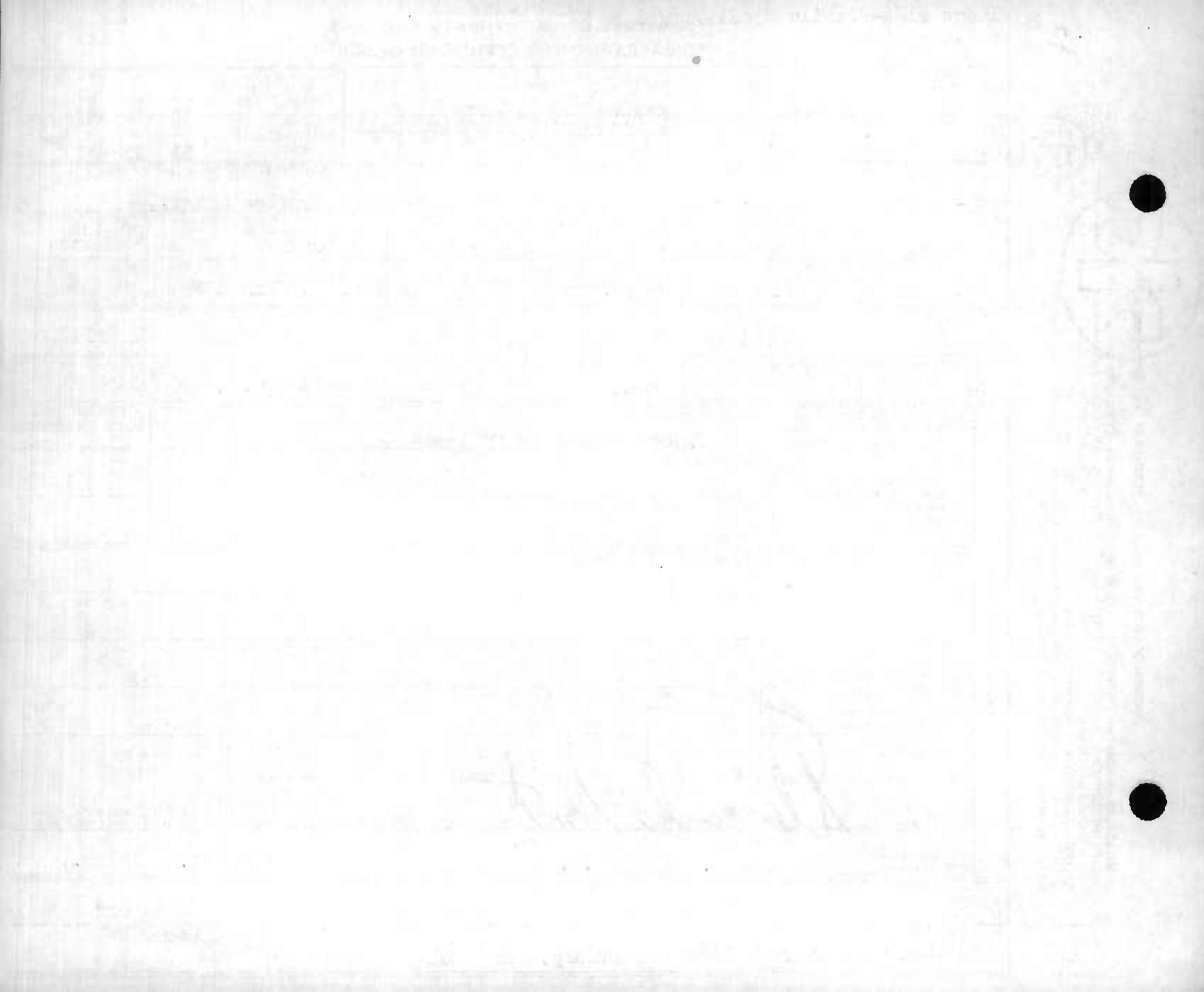
troupe de

newton wilson

golias sandel

moderna cultura de portugues

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 29349		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR			
Damon			Maurice Carroll			<input checked="" type="checkbox"/> 11 22 19 81			M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE [IN YEARS LAST BIRTHDAY]	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.			
Male	Black	7 1 81	YRS.	4								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			2c. DATE PRONOUNCED DEAD			2d. HOUR	
Maryland		U.S.A.						11 22 19 81			Noon M	
9. BALTIMORE CITY OR COUNTY OF DEATH		Charles County, MD.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
LaPlata		Physicians Memorial Hospital			None			None				
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Nanjemoy		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 6, Box 104				
14. FATHER'S NAME FIRST James		MIDDLE Wallace		LAST Johnson		15. MOTHER'S MAIDEN NAME FIRST Sharon		MIDDLE Lucretia		LAST Carroll		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			None			Sharon Carroll			Rt. 6, Box 104 MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												
7980 IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost.												
DUE TO, OR AS A CONSEQUENCE OF												
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY STREET, FACTORY, FARM, ETC.			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
22b. TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER												
22c. DATE SIGNED 11/23/81												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11-25-81		23c. NAME OF CEMETERY OR CREMATORIAL Oak Grove Cemetery		23d. LOCATION CITY OR TOWN Grayton		23e. COUNTY Charles		23f. STATE MD		
24. FUNERAL DIRECTOR NAME Thornton's Funeral Home		ADDRESS Pomonkey, MD		25a. DATE REC'D. BY REGISTRAR DEC 1 1981		25b. REGISTRAR'S SIGNATURE						
BP _____												
DHMH-17 (VR A15 ME(5))												
15M 2/90												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8129350	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
ALBERT J. Connors						11 29 81				9:34P			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE		white		MONTH	DAY	YEAR	51			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
MO		U.S.A.						Charles			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
12a. At Plata, MD			12b. Physicians Memorial Hosp			12a. U.S. Air Force			12b. Military				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MD			Prince George		Bowie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1608 Pittsfield Lane				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Daniel.			A.		Connors	Unknown					Birnstin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Air Force			47-99			1608 Pittsfield Lane			Bowie, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)													
4100 Cardiac - respiratory arrest.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first													
DUE TO, OR AS A CONSEQUENCE OF (c)													
Coronary artery disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
—			—						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. — 19			—							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —							
22a. I certify that (I) (this hospital) attended the deceased from 11/29/81 to 11/29/81, that (I) (we) last saw the deceased alive on 11/29/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE						22c. DATE SIGNED				
Terry A. Bowlsnare M.D.			M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			11/29/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
Terry A. Bowlsnare M.D.			701 East Charles Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	
Burial			12/3/81			Arlington Nat'l. Cem.			Arlington			Virginia	
24. FUNERAL DIRECTOR NAME			George P. Kalas Funeral Home			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
			6160 Oxon Hill Rd., Oxon Hill, Md.			DEC 4 1981			Terry				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8129351				
										REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Nov. 16 81		824 P.M.			
MARY E Datcher														
3 SEX			4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR			
Female			Black		11/18/1900			80 81 yrs			IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS MONTHS DAYS			
Maryland			USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Charles			HOURS MIN			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
La Plata			Physicians Memorial Hospital							Housewife			Private	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE Maryland				
13b. COUNTY Charles										13c. CITY OR TOWN Nanjemoy				
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS BOX 71 A Nanjemoy, Md.				
14 FATHER'S NAME FIRST			MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Thomas					Alcinda					Posey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			N/A		217-300643			Rudolph Datcher			Nanjemoy, Md. 20662			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <i>Cardiac myopathy</i>														
4354 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.														
(b) <i>diabetes mellitus</i>														
(c) <i>renal failure</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 22 1981</i> to <i>11-10 1981</i> , that (I) (we) last saw the deceased alive on <i>Oct 22 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Ignacio T. Garcia, M.D.</i>										22c. DATE SIGNED <i>11-17-81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. I Garcia</i>										22e. ADDRESS <i>La Plata, Md 20662</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial			11-20-81		Mt. Hope Church			Ironsides, Charles, Md.						
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR				
Thornton's Funeral Home										25b. REGISTRAR'S SIGNATURE <i>Home Garcia</i>				
DHMH-16 20M (VRA 15, 4) 7/78										NOV 24 1981				



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29352

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.
Ronald J.			Dohler, Jr.			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 11 6 1981
Male	White	12/27/57	23 yrs.			2b. HOUR M 1:30
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.
Md.	U.S.A.					
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nuclear Plant Opr. Elec Co	
13a. STATE Md.	13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2605 Rooks Head Place	
14. FATHER'S NAME FIRST Ronald	MIDDLE J.	LAST Dohler Sr.	15. MOTHER'S MAIDEN NAME Brenda		MIDDLE P.	LAST Scaffee
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) -	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-78-5766	17. INFORMANT Catherine Dohler (wife)		ADDRESS same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			IMMEDIATE CAUSE (a) <u>Blunt injury to the trunk with laceration</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>of right main stem bronchus</u> (c)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 11 6 1981	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto impact				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway	21f. LOCATION STREET Rt. 231, Hughesville, Charles County, Maryland	CITY OR TOWN	- COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE	TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER DATE SIGNED 11-8-81		
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION CITY OR TOWN			
Burial	11/11/81	Gardens of Faith	Balto.	COUNTY STATE		
24. FUNERAL DIRECTOR NAME	ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 10 1981	25b. REC'D. BY REGISTRAR'S SIGNATURE Md. <i>James J. Mathews</i>		
Seiffimunek Funeral Home, Inc.	3331 Brehms Lane, Balto. Md. 21213					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS DEPARTMENT, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

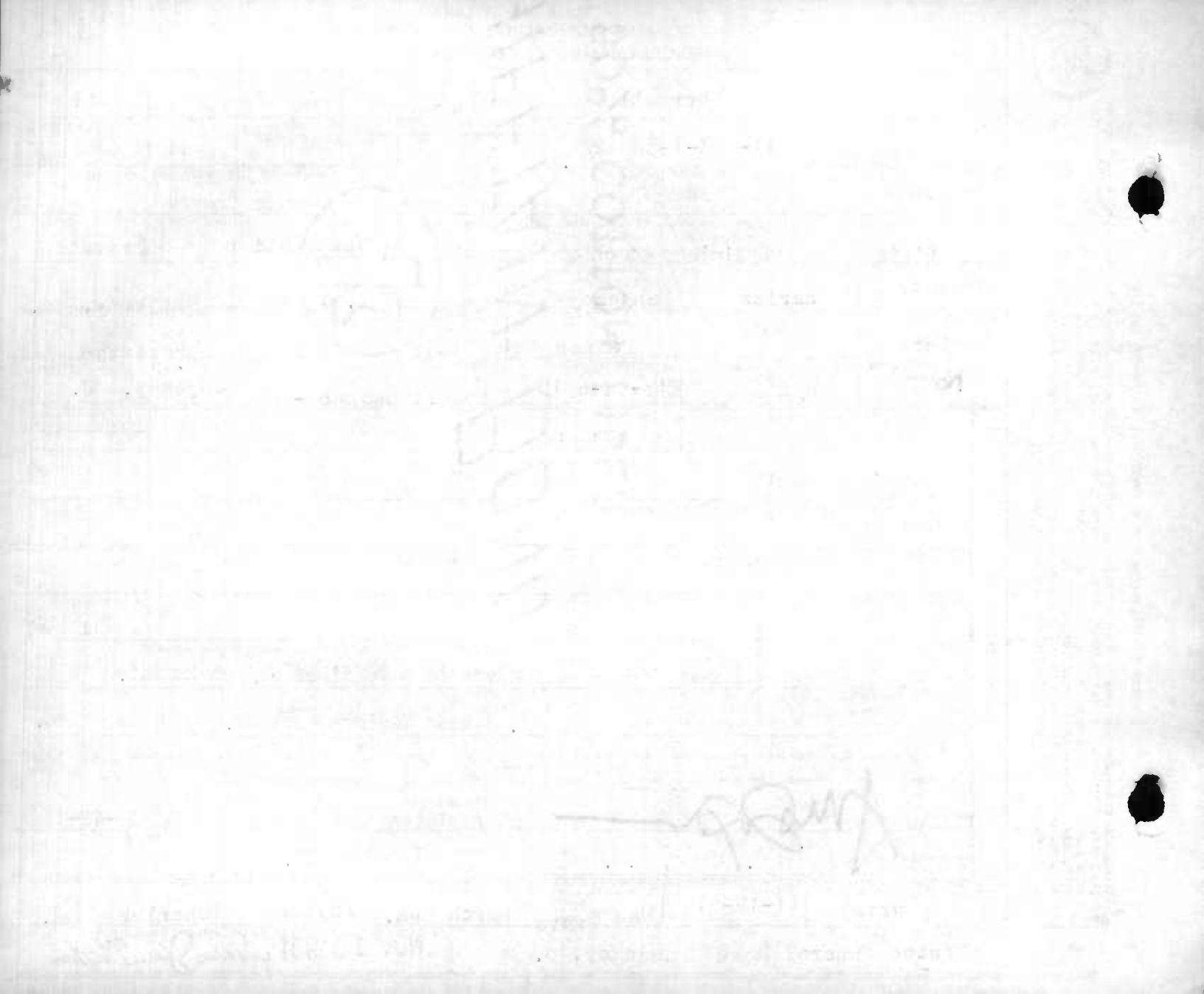
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										29353							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR				
JOY				ANNETTE		FOX		<input checked="" type="checkbox"/>		11-24-81			11:00 A.M.				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR		
female	white	May 9, 1949		32 yrs.						11-24-81					10:10 A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		Charles County							
Wash. D.C.		U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>		Charles County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
LaPlata		Physicians Memorial Hospital		Housewife		Own Home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Md.		Charles		LaPlata		YES <input type="checkbox"/>		Estevez Road, Rt. 3									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16. SOCIAL SECURITY NO.		17. INFORMANT		Rt. 925 South		DeMarr			
Augustin				Fitzwilliam		Joy		219-48-9119		Joy Pankake,		Waldorf, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										ACUTE DRUG INTOXICATION						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
950s Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				<input checked="" type="checkbox"/>		YES <input checked="" type="checkbox"/>								NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 11/21/81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET Star Rt. 3		CITY OR TOWN Charles Co., Md.											
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 11-25-81	
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street											
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN Waldorf, Chas.		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Burial		11-28-81		Trinity Memorial Gard.		Md.		Huntt Funeral Home, Waldorf, Maryland		DPR 1 1091		Thurman					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29354		
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 11 DAY 13 YEAR 81									2b. HOUR 24 HOUR 3:57 a.m.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST PAUL			MIDDLE Shernell			LAST GAINES					
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH 11 DAY 23 YEAR 1958		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		7. IF UNDER 1 YR. MONTHS 0		8. IF UNDER 24 HRS. DAYS 0				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County						
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction			12b. KIND OF BUSINESS OR INDUSTRY Private		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Nanjemoy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 94C Nanjemoy, Md.					
14. FATHER'S NAME FIRST Robert			MIDDLE			LAST Gaines			15. MOTHER'S MAIDEN NAME FIRST Clair			MIDDLE LAST Banister		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Robert Gaines -			ADDRESS Rt. 1 Box 94C Nanjemoy, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 <input checked="" type="checkbox"/> 11-13 8			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object impact.			21d. LOCATION STREET Rt. 6 near Taylors Neck Rd. CITY OR TOWN Charles COUNTY Md. STATE					
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Ann M. Dixon, M.D.</u>													TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.													DATE SIGNED 11-13-81	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-17-81			23c. NAME OF CEMETERY OR CREMATORIAL Oak Grove			23d. LOCATION CITY OR TOWN Grayton			23e. COUNTY Charles STATE Md.		
24. FUNERAL DIRECTOR NAME Thornton Funeral Home ADDRESS Pomonkey, Md.													25a. DATE REC'D. BY REGISTRAR NOV 18 1981	
													25b. REGISTRAR'S SIGNATURE <u>Frances Jean Harten</u>	

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

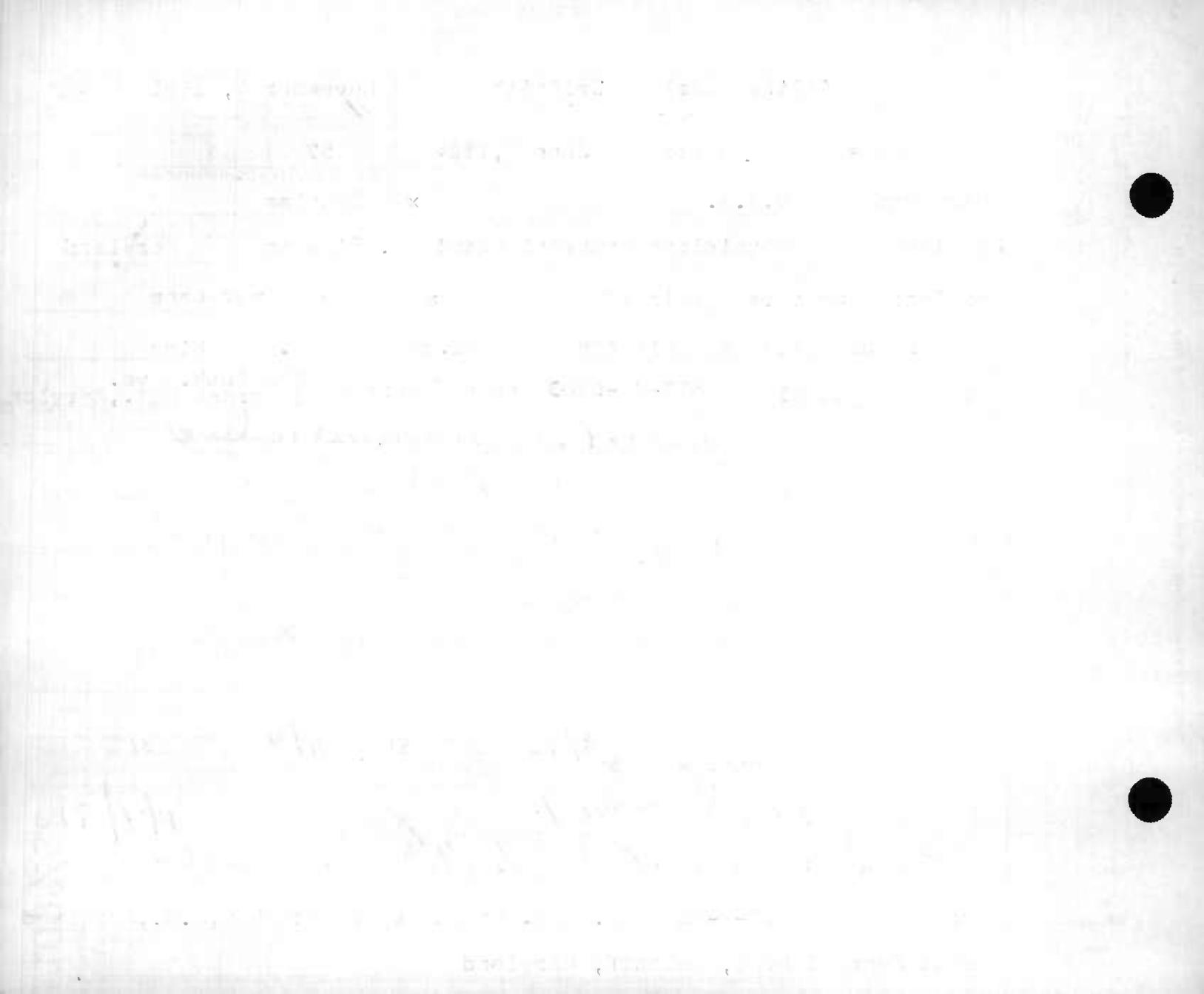


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

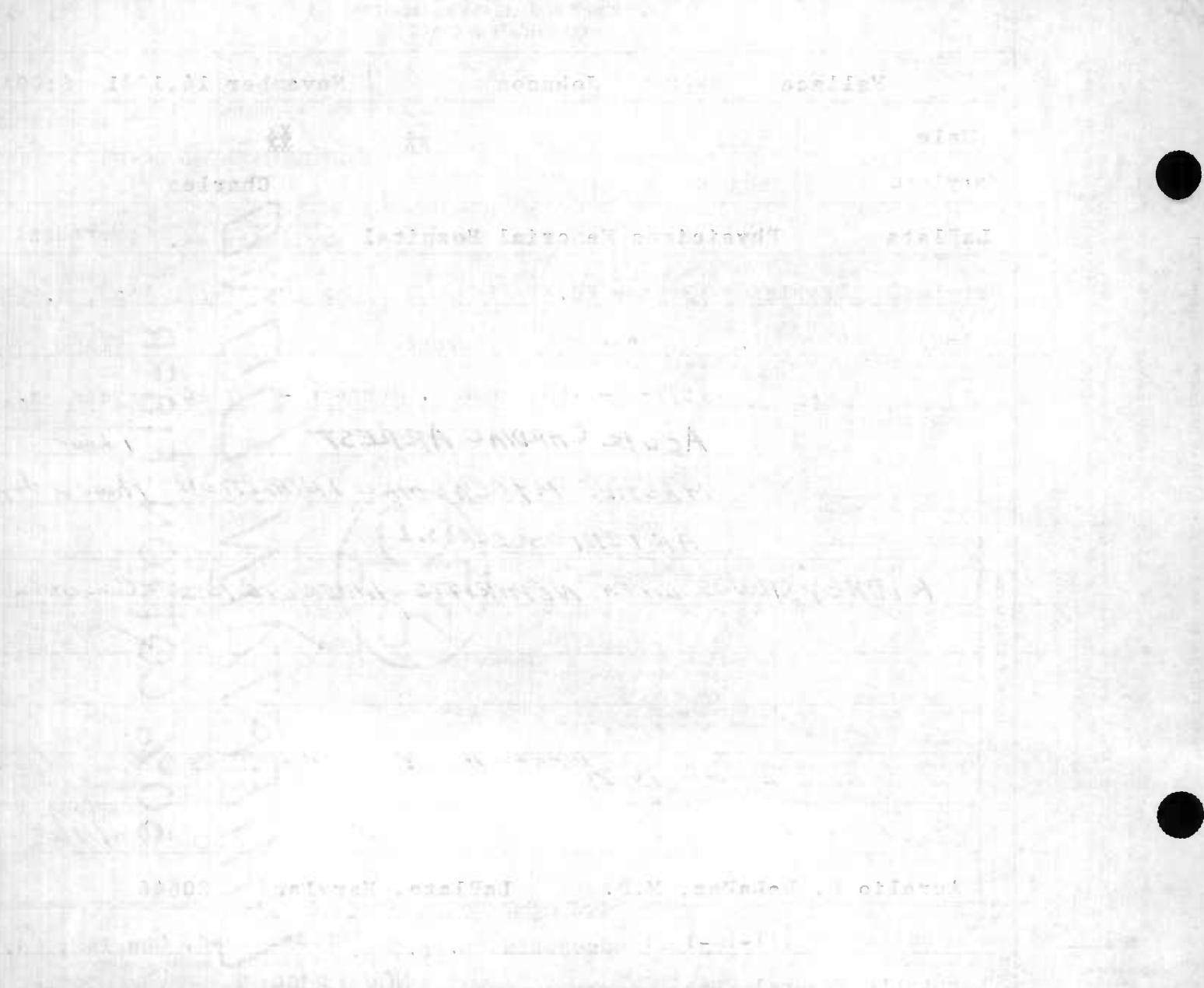
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8129355	
										REG. NO.	
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				William Earl Griffith		2a. DATE OF DEATH MONTH YEAR November 4, 1981 11-4-81		2b. HOUR 7:15 AM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles		MD.			
10 CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital.		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Fireman		12b. KIND OF BUSINESS OR INDUSTRY Maryland					
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3029 Walnut Lane			
14. FATHER'S NAME FIRST Arthur		MIDDLE William		LAST Griffith		15. MOTHER'S MAIDEN NAME FIRST Grace		MIDDLE M.		LAST King	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO WW II		16c. INFORMANT 577-28-6882 Annie Thompson		17. ADDRESS 3809 26th. Ave. Hillcrest Hot., Maryland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Severe Congestive Heart Failure</i> <i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <i>Ventricular Arrhythmia</i> (c) <i>Arthritic Aorta Myocardial Infarction</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 3/15 1981							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <i>Jean H. Blatner</i> attended the deceased from <i>3/15/81</i> to <i>11/4/81</i> , that (s) (we) last saw the deceased alive on <i>10/27/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jean H. Blatner</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/4/81					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Grace H. Blatner</i>		22f. ADDRESS <i>La Blatner, MD 20646</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-9-81		23c. NAME OF CEMETERY OR CREMATORIAL Md. Vet. Cemetery		23d. LOCATION CITY OR TOWN Cheltenham, P.G., Maryland		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Huntt Funeral Home, Waldorf, Maryland</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR 11-9-81		25b. REGISTRAR'S SIGNATURE <i>Jean Blatner</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician, page 3  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8129356		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Wallace	MIDDLE Harris	LAST Johnson	2a. DATE OF DEATH November 14, 1981			MONTH DAY YEAR	2b. HOUR 6:00 A.M.		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 12 DAY 14 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED X NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Charles			MD.			
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Explosive Wk.			12b. KIND OF BUSINESS OR INDUSTRY Government					
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Bryans Rd.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 205 Bryans Road, Md. 20616				
14. FATHER'S NAME FIRST Alonzo		MIDDLE T.		LAST Johnson		15. MOTHER'S MAIDEN NAME Florence		16. ADDRESS Clark				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Agnes M. Johnson - Box 205 Bryans Rd., Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) KIDNEY STONES WITH NEPHRITIS, LIVER WITH Passive Congestion												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from November 11, 1981, to November 14, 1981, that (I) (we) last saw the deceased alive on November 13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/14/81		
22b. SIGNATURE Aurelio C. de la Paz		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aurelio C. DeLaPaz, M.D.		22e. ADDRESS LaPlata, Maryland 20646										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-19-1981		23c. NAME OF CEMETERY OR CREMATORIAL Macedonia Bp. Ch. Cem.		23d. LOCATION CITY OR TOWN Bryans Road, Charles, Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Thornton's Funeral Home		ADDRESS Pomonkey, Md.		25a. DATE REC'D. BY REGISTRAR NOV 18 1981		25b. REGISTRAR'S SIGNATURE Barney Jan Nathan						
BP_____												



Items #18a-22a Film G565 3/3/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 29357

FOR  
1 - STATE  
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 4 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)						FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/>				2b. HOUR MONTH DAY YEAR		
Paul E. Oyer									11	19	1981	M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY					
Male	White	NOV 01 1941	40 yrs.	MONTHS DAYS	HOURS MIN	11 19 1981	La Plata	Physicians Memorial Hospital	MACHINIST MATE	U.S. NAVY					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		13a. STATE NEW YORK			13b. COUNTY ONEIDA	13c. CITY OR TOWN UTICA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Unknown	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE NEW YORK			13b. COUNTY ONEIDA	13c. CITY OR TOWN UTICA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Unknown	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Richard John Oyer						Bertha M. KALABASA		YES <input checked="" type="checkbox"/>		077-34-9633		Wife- Marilyn Oyer, 8 Riverview Vilg Indhead, Md/			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF  9170 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>Blunt trauma of chest</u> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR, MONTH, DAY, YEAR 2+ P.M. 11/19/81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) As participant in volleyball game											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) volleyball court		21f. LOCATION STREET Naval School CITY OR TOWN Indian Head COUNTY Chas. Co., Md. STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Thomas D. Smith</u> TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St. Balt., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-26-1981		23c. NAME OF CEMETERY OR CREMATORIAL Crown Hill Memorial		23d. LOCATION CITY OR TOWN Kirkland, Oneida, New York		23e. REGISTRATION NUMBER NOV 23 1981 Name							
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., 8655 Georgia Ave, S.S.															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 9 3 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST <b>MAMIE</b>	MIDDLE	LAST <b>POSEY</b>	2a. DATE OF DEATH <b>NOVEMBER 17, 1981</b>	MONTH DAY YEAR	2b. HOUR <b>5:30 A M</b>		
3. SEX <b>FEMALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH <b>JULY</b>	DAY <b>31</b>	YEAR <b>1903</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS HOURS <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b>		
10. CITY OR TOWN OF DEATH <b>LaPlata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Nanjemoy</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13a. STREET ADDRESS <b>General Delivery, Nanjemoy</b>				
14. FATHER'S NAME FIRST <b>William</b>	MIDDLE <b>H.</b>	LAST <b>ROSS</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Florence</b>	MIDDLE	LAST <b>Dent</b>	ADDRESS <b>206 Pusey Street Chester, PA.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>N/A</b>	17. INFORMANT <b>Raymond Ross</b>	APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2059</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). <b>Myelogenous Leukemia</b>								
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>11-9 1981</b> to <b>11-16 1981</b> , to <b>11-16 1981</b> , that (I) (we) last saw the deceased alive on <b>11-16 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Ignacio T. Garcia, M.D.</b>	22c. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <b>11-17-81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ignacio T. Garcia, M.D.</b>	22e. ADDRESS <b>LaPlata, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-21-81</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Hope Bp. Ch.</b>				23d. LOCATION CITY OR TOWN <b>Ironsites, Charles, Md.</b>	COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Thornton's Funeral Home</b>	ADDRESS <b>Pomonkey, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>NOV 24 1981</b>				25b. REGISTRAR'S SIGNATURE <b>James J. ...</b>		

salvage

Decision factors in determining results

etc.

but little evidence of a causal relationship

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Leona Estelle Quade												11	9	81	7 44 P.M.	
3. SEX <b>Female</b>			4. RACE <b>Cau.</b>			5. DATE OF BIRTH MONTH <b>Dec. 6, 1893</b>			YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 MRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b>			87	MONTHS	YEARS	MONTHS	YEARS
10. CITY OR TOWN OF DEATH <b>La Plata</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Charles County Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>							
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Charles</b>			13c. CITY OR TOWN <b>La Plata</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>327 St. Mary's Avenue</b>				
14. FATHER'S NAME FIRST <b>Charles</b>			MIDDLE <b>B.</b>			LAST <b>Robey</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			MIDDLE <b>Alice</b>			LAST <b>Robey</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. -----			16c. DATE OF DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>			17. INFORMANT ADDRESS <b>William L. Gibbons same as 13</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>			18b. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Old Cerebrovascular Accident</b>			18c. DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic Peripheral Vascular Disease</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Gangrene &amp; Septic Ulceration of Foot</b>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>11-25</b> , 19 <b>70</b> , to <b>11-9</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>10-19</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Henry L. Burke, M.D.</b>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN			22e. DATE SIGNED <b>11-9-81</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry L. Burke, M.D.</b>			22e. ADDRESS <b>La Plata, Maryland 20646</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-12-81</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Old Field's Cem.</b>			23d. LOCATION CITY OR TOWN <b>Hughesville, Charles, Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, Waldorf, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1981</b>			25b. REGISTRAR'S SIGNATURE <b>J. Huntt</b>										

4

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												29360	
												REG. NO.	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF EST. DEATH MATED			MONTH DAY YEAR	2b. HOUR	
		Lawrence Joseph J. Therres						<input checked="" type="checkbox"/> 11-24-81					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
male		white		3-30-1924		57 yrs.						11-24-81	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.						Charles County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
LaPlata		Physicians Memorial Hospital		Mechanic		Automobile							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Charles		Hughesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #1 Box 300					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Joseph		N.		Therres		Catherine		M.		Koller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		N/A		215-14-7278		Frances B. Therres		Same as Line #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Hanging</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
{ (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) basement		21f. LOCATION STREET Rt. #1 Box 330 Hwy. 381 CITY OR TOWN Hughesville, Maryland COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on <b>Autopsy <input checked="" type="checkbox"/></b> , <b>Inspection <input type="checkbox"/></b> , <b>Inquiry <input type="checkbox"/></b> , and in my opinion death resulted from: <b>Natural causes <input type="checkbox"/></b> , <b>Accident <input type="checkbox"/></b> , <b>Suicide <input checked="" type="checkbox"/></b> , <b>Homicide <input type="checkbox"/></b> , <b>Undetermined manner <input type="checkbox"/></b> .													
ACTUAL SIGNATURE <i>Hospital One Year</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 11-25-81							
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11-28-81		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN Waldorf COUNTY Charles Md. STATE							
Burial													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 1 1981		25b. REGISTRAR'S SIGNATURE <i>James Janes</i>							
Huntt Funeral Home		Waldorf, Maryland											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from us as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81 29361						
										REG. NO.						
1. FOR STATE REGISTRAR																
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
CATHERINE J. TRIGALET						11 16 81						9:25A M				
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Cau.			MONTH DAY YEAR			88			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			Sept. 13, 1893			9. BALTIMORE CITY OR COUNTY OF DEATH			CHARLES MD.				
New York			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
LA PLATA			PHYSICIANS MEMORIAL HOSPITAL			Cafeteria Worker			School Board							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland			Charles			Nanjemoy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			MEJA Farm				
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
Michael			Callaghan			Bridget						Shea				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			099-14-2768			Mary J. Bagnato same as 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>																
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Arrhythmia</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASID</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-14, 19 81, to 11-16, 19 81, that (I) (we) lost saw the deceased alive on 11-16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>Henry L. Burke, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-16-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			CALVERT & HOWARD STREETS LA PLATA, MD.										
HENRY L. BURKE, M.D.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Burial			11-19-81			Holy Cross Cemetery			Brooklyn, New York							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Hunt Funeral Home			Walney			NOV 20 1981			James J. Walker							
DHMH-16 30M 2/80 (VRA 15, 4)																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be palled up above.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	9	3	6	2				
												REG. NO.										
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Janie			C.			White			Young			Nov. 27, 1981						2:22A M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)									IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR			84									MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia			USA			Jan. 14, 1897									Charles County, MD							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
LaPlata			Physicians Memorial Hospital						Housekeeping			Domestic										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS										
Maryland			Charles			Newburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route 1 Box 99 D										
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME										
												(Unobtainable)										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT																
No			230-50-7669 A			John C. Young			Same as Item #13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART I. DEATH WAS CAUSED BY:																						
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>																						
2387 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Shock</i>																						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>myeloproliferative Disorder</i>																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>11-26-1981</i> to <i>11-27-1981</i> , that (I) (we) last saw the deceased alive on <i>11-26-1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE <i>hsrath</i>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Girija S. Rath</i>			22e. ADDRESS <i>Waldorf, Maryland 20601</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/1/81			23c. NAME OF CEMETERY OR CREMATORIAL Fairfax City			23d. LOCATION CITY OR TOWN Fairfax			COUNTY	STATE Fairfax Co., Va.									
24. FUNERAL DIRECTOR NAME <i>Walter J. Holt</i> ADDRESS <i>Cameron &amp; Alfred Sts.</i> Cunningham Funeral Home, Inc. Alex., Va.						25a. DATE REC'D. BY REGISTRAR DEC 3 1981			25b. REGISTRAR'S SIGNATURE <i>Diane Jan Koster</i>													

188-8030